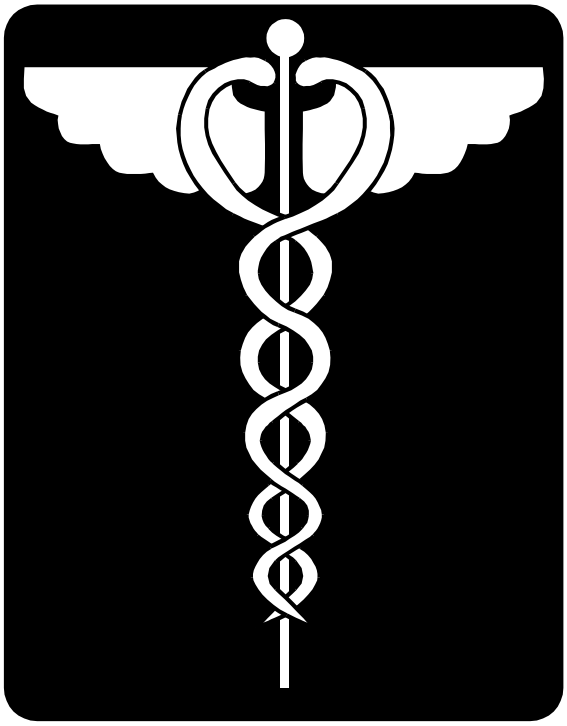
2004 Statewide Medical & Health Disaster Exercise

EXERCISE CONTACT TOOLKIT

State of California
Emergency Medical Services Authority



NOVEMBER 18, 2004

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise

Executive Summary

Dear Exercise Participant:

It is time again for the Statewide Medical & Health Disaster Exercise! This is California's sixth annual exercise incorporating hospitals and other healthcare providers, including long-term care facilities and clinics, pre-hospital care providers, auxiliary communication networks, blood banks, local public health and other local and regional governmental agencies.

The last few years, the exercise has focused on "man-made" disasters that confront emergency managers and the healthcare community. In 2003, the exercise focus was a biological terrorism event involving *Yersinia pestis,* or plague. This year, the Exercise Planning Committee has designed the scenario to build on the issues and challenges that would confront the State should a biological terrorism event occur in California, focusing on surge capacity, scarce resources (ventilators, staff, and inpatient beds), laboratory specimen processing, security and infection control. This exercise meets the requirements of the Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) grant requirements to conduct bioterrorism exercises.

The Operational Area (county) Exercise Contact is your point of contact for planning, questions and organization for the exercise. We encourage you to contact the Operational Area Exercise Contact early in the planning process to assist you in the execution of the 2004 exercise. Please see page 44 of this guidebook for the listing of Exercise Contacts. To assist the Operational Area (OA) Exercise Contacts in planning and executing the exercise, there will be two planning conferences convened by the Emergency Medical Services Authority. The dates of the planning conferences will be announced in August.

Important Timelines and Deadlines

September 24, 2004	Deadline to fax Intent to Participate Form to the Operational Area Medical/Health Exercise Contact (see list of contacts on page 30).
October 8, 2004	Deadline for Operational Area Exercise Contacts to fax the OA Intent to Participate Form to the Regional Disaster Medical/Health Specialist (see page 23)
November 18, 2004	**The exercise will be conducted from 8:00 am until 12:00 pm.**
December 10, 2004	Deadline to complete and mail the appropriate provider specific Master Answer Sheet to the California Emergency Medical Services Authority (see address on form) to receive a participation certificate.

Note: For all Exercise Contacts, planning meetings will be scheduled for August, 2004. Watch for details of the upcoming conferences.

Thank you for your commitment to disaster medical planning and preparedness.
We look forward to hearing about your successful exercise!

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 18, 2004

Exercise Contact Toolkit

Table of Contents

Exercise Contact Toolkit
A GUIDE FOR MEDICAL/HEALTH OPERATIONAL AREA EXERCISE CONTACTS
November 18, 2004

The following materials are offered to assist you in your preparation for and execution of the exercise.

Pre-Exercise Checklist

Preparing the Materials
Compile, at a minimum, the following materials:

- 2004 Statewide Medical & Health Disaster Exercise Guidebook for November 18, 2004 from the Emergency Medical Services Authority, focusing on the following documents:
  - Exercise Objectives (Exercise Guidebook, page 2)
  - Background Scenario for Exercise (Exercise Guidebook page 6)
  - Exercise Day Scenario (Exercise Guidebook, page 7)
  - Intent to participate Forms (Exercise Guidebook, page 16 and ACS Guidebook, page 12)
  - Conducting the Exercise: Tips for Hospitals (Exercise Guidebook, page 37)

  Note: Supplies of the printed Exercise Guidebook may be limited. For additional copies, please visit the website at www.emsa.ca.gov/dms2/hospambex.asp or contact Cheryl Starling, RN via email at Cheryl.starling@emsa.ca.gov.

- Messages developed from the scenario to provide to the participants within the Emergency Operations Center (EOC) and messages for the Auxiliary Communications System groups within your OA.
- A list of key contact information for participants and government organizations.
- Critique forms developed by your organization and the "Hotwash/Debriefing Form" in this Exercise Contact Toolkit, (page 24).

Coordination with Other Organizations
The 2004 exercise focuses on the medical and health system as it responds bioterrorism and an outbreak of botulism, building on the activities and relationships of the 2003 exercise. The background scenario sets the stage of events leading up to the exercise. The medical and health system must respond to an overwhelming influx of patients and shortages of resources including staffing, supplies, equipment and medications.

Recommended Primary Contacts and Participants in the Operational Area

1. Each Exercise Contact is strongly encouraged to coordinate with the following entities within the operational area no later than September 24, 2004 to ascertain their participation in the exercise:
   - ❑ Hospitals and clinics
   - ❑ Ancillary healthcare facilities (skilled nursing facilities, other care facilities)
   - ❑ Ambulance Providers and Emergency Medical Services
   - ❑ Local Public Health Department
   - ❑ Local Emergency Medical Services Agency
   - ❑ Local Office of Emergency Services
   - ❑ Auxiliary Communications System (ACS) providers
   - ❑ Medical and Health Operational Area Coordinator (MHOAC)

2. Each entity participating in the exercise is encouraged to designate a representative to liaison with the Exercise Contact and attend meetings in preparation for the exercise.

3. The Exercise Contact is encouraged to conduct at least two (2) pre-exercise, preparatory meetings with the participants within your Operational Area (OA) to:
   - ❑ Determine level and scope of agency and OA participation and collaborate on the development of community specific scenario events based on the statewide scenario.
   - ❑ Provide participants with phone numbers to reach the Exercise Contact on the day of the exercise, as well as relevant fax and e-mail addresses.
   - ❑ Inform participants of potential conflicts or competing activities that may occur that day.
   - ❑ Communicate procedures to terminate the exercise both within the OA and within each participating entity, should an actual emergency occur during the exercise. Many agencies use the term “time out” to stop exercise play.
   - ❑ Identify where and how information is to be communicated within participating organizations during the exercise, and how it is to be marked, e.g., “This is a Test,” “This is a Drill,” or “This is an Exercise.”
   - ❑ Identify the person (or agency) that will enter information into RIMS during the exercise.
   - ❑ Invite other participating agencies, departments or organizations to briefings or training for the exercise.
   - ❑ Contact and update other agencies, departments or organizations about any last-minute changes in participation or communications.
   - ❑ Assist the participants in finding community volunteers to participate in the exercise to increase realism in the play.

Other Recommended Contacts and Participants in the Operational Area

Expanding the exercise in your OA is strongly recommended and encouraged. The following entities should be considered for involvement in the exercise, if possible:

- ✓ MMRS (if applicable in the city/OA)
- ✓ Medical Reserve Corps

- ✓ Local law enforcement and FBI
- ✓ Local fire departments
- ✓ Local schools and/or school officials (even if only in a tabletop)
- ✓ Medical Examiner (Coroner)
- ✓ Environmental Health
- ✓ Public Utilities
- ✓ Others as identified by the scenario or the unique OA entities

Coordination with the Media
Collaborate with the local agencies'/department's Public Information Officer to define how the media will be addressed during the planning process (media or press releases), during the exercise (press briefings and conferences, written risk communication messages), and post exercise (communicating the success of your community-wide exercise). Prepare media releases in advance and sound bites can even be pre-recorded. For examples of Public Service Announcements and Media Advisories, see the Exercise Guidebook, page 15.

Scheduling Personnel, Space, and Equipment
It is recommended that facility and organization staff assigned to the exercise are notified well in advance to coordinate their schedules and plan for participation. For critical exercise positions or assignments, consider scheduling back-up staff that are also briefed and trained prior to the exercise.

- ❑ Announce the exercise date on local agencies/departments calendars, in-house publications or computer schedules so all involved personnel save the date when they are scheduling other activities.
- ❑ Identify and reserve the exercise location/space before the exercise.
- ❑ Assess the exercise area to make sure construction or other changes do not hinder the layout for performance of the exercise, e.g., removal of the phone lines from the room, or removal of the chairs and tables.
- ❑ Develop a checklist of the equipment you will need to support the exercise.
- ❑ Check all equipment for proper functioning and operation before the exercise.

Reporting Intent
Each participating entity should notify the Exercise Contact of its intent to participate and complete the "Intent to Participate" form (see page 16 in the 2004 Statewide Medical & Health Disaster Exercise Guidebook). The "Intent to Participate" form does not ask for the level of exercise play in the organization, but only their intent to participate. The participating entity should fax the "Intent to Participate" form to the Exercise Contact by **August 27, 2004**. Upon receipt of the form, the Exercise Contact will compile the participant totals on the "Operational Area Intent to Participate" form (see Exercise Toolkit, page 22).

The Exercise Contact will fax the "Operational Area Intent to Participate" form to the Regional Disaster Medical Health Specialist (RDMHS) no later than close of business on **September 10, 2004.** (See page 23 in this toolkit for the listing of RDMHS contact and fax numbers).

Developing Local Scenarios
The scenario in the 2004 Statewide Medical & Health Disaster Exercise Guidebook details a sequence of events to be used by participants. This sequence provides the overall anticipated

schedule of activities that all participants will incorporate into the community exercise. Local agencies and departments may plan an extended exercise scenario or alter the scenario to meet the needs of

the OA or organization. Local agencies/departments will decide the scale and intensity of participation and their role in transmitting information from the healthcare providers to local government.

To assist hospital participants in planning and executing a facility-wide exercise, please see "Conducting the Exercise: Tips for Hospitals" in the Exercise Guidebook, page 32.

Coordination with Auxiliary Communications Systems (ACS) Staff
The 2004 Statewide Medical and Health Disaster Exercise Planning Committee have developed an ACS guidebook. The guidebook can be found on the website at ***www.emsa.ca.gov/dms2/hospambex.asp*** or by contacting Cheryl Starling, RN at cheryl.starling@emsa.ca.gov. In order to enhance the exercising of ACS staff and integrate ACS more closely into the exercise, two-way messages have been developed and are available in the ACS Exercise Guidebook. The messages are listed on a Master Sequence of Events List and provides mock messages for play. Some of the messages require information gathering before answers can be sent, therefore it is suggested that ACS be incorporated into the Emergency Operations Centers at all levels to increase reality of information and message transmission.

If there is an actual emergency during the exercise play, a message, "TIME OUT- All Transmissions Must Stop!" will be repeated three times and all ACS traffic will cease.

Recommended Exercise Day Activities

Pre-Exercise Survey of Resources
Changes often occur at the last minute and can interfere with a successful exercise. Organize a team of "checkers" who do nothing more than check facility readiness, materials, storage lockers, phones, fax machines and other communications systems the evening before and the morning of the exercise.

Briefing of Participants
Provide the participating staff job action sheets, background information, organizational charts, pertinent policies and procedures and role expectations before the exercise begins to increase participant comfort level and exercise success. At the minimum, the facility should be aware of the exercise in progress.

"This Is Only An Exercise!"
During the briefings, and throughout the exercise on November 18th, it is very important to stress that this is **only an exercise** to all participants and agencies/departments. Written materials and scripts should denote and emphasize this is only an exercise. Oral communications and instructions should reinforce the "exercise" status. This is a learning opportunity for the staff, the facility/organization and local government and can assist in assessing the effectiveness of the emergency management plan(s) and identify areas for improvement and refinement.

Terminating the Exercise for an Actual Emergency
Should there be a need to stop or "pause" the exercise due to an actual emergency situation or event, the State Exercise Control Cell will notify the RDMHS to terminate the exercise. The State Exercise

Control Cell will give a "**Terminate the Exercise**" order and the exercise will be immediately terminated at the State and regional level. Each Operational Area Exercise Contact will be notified by the RDMHS to terminate the exercise.

It is recommended that the OA Exercise Contact **and** each participating organization establish a similar "Terminate the Exercise" command in the case of actual emergency or safety issue.

Reporting Situation/Status Information to the Operational Area (OA)
Each participating agency will compile situation and status information utilizing their own operational area forms and submit reports to the Operational Area officials according to OA policies.

The participants will begin transmitting their situation/status reports to the OA by 11:00 am on the day of the exercise (see the exercise scenario).

RIMS: Reporting Operational Area Situation/Status into RIMS
Note: It is very important that the "**training**" section in RIMS is utilized to enter data during the exercise. When RIMS is accessed, be sure that you are in the TRAINING SECTION before data entry.

The Response Information Management System (RIMS) is an Internet based information management system and consists of a set of databases designed to collect information on the disaster situation, communicate action plans and receive mission requests. RIMS is accessed and utilized by operational areas, regional and State governmental agencies.

Important RIMS Tips and Considerations

- **RIMS Access Issues:**
  a. Established RIMS users have a password into RIMS and will log onto RIMS using their individual assigned access and password.
  b. If you do not have RIMS access, please contact Cheryl Starling at the EMS Authority at cheryl.starling@emsa.ca.gov for a temporary exercise only password assignment and the procedure for obtaining RIMS access.
- RIMS classes will be scheduled in September and October. Please check the EMSA website at **www.emsa.ca.gov** or email **cheryl.starling@emsa.ca.gov** for more information.
- The **RIMS Situation AND the RIMS Event Reports** will be entered into RIMS before the exercise by the State Exercise Control Cell, and should not be re-entered by the operational area or local governmental agency. This will ensure that all RIMS entries will be entered into the disaster exercise fields.
- Please enter RIMS information only under the ***Status Report*** Field, not the Event or Situation report field.
- The Event is named: ***2004 Medical and Health Disaster Exercise***. It is very important to enter the Operational Area RIMS information under this event name and not a similar

exercise/event/name. Do not create a new name for the exercise, but enter all data under this event name only.

On the day of the exercise, November 18, 2004, the Operational Area will enter information into RIMS at the following intervals:

- ❑ Enter an initial status report **within one (1) hour of the beginning of the exercise**, or at approximately 9:00 am. This initial report is a "snap-shot" of the status of and critical issues confronting the OA.
- ❑ Update and modify the initial report as additional information or resources are requested.
- ❑ Enter final exercise status information obtained from participants beginning at 11:00 am or later, compiling the information and reporting aggregate data.

Essential initial status (or "snap-shot") **information** to be entered into RIMS should include:

- ❑ Hospital Status (RIMS Status Report Number 8.b.)
- ❑ Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- ❑ Overall Medical/Health Critical Issues (RIMS Status Report Number 19)
- ❑ Bed Availability (RIMS Status Report, Bed Availability, Resources Available)

Expanded and ongoing status information to be entered into RIMS may include, but is not limited to:

- ❑ Hospital Status (RIMS Status Report Number 8.b.)
- ❑ Bed Availability for the next 8 and 24 hours (RIMS Status Report, Bed Availability, Resources Available)
- ❑ Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- ❑ Status of SNF's, clinics and/or Field Treatment Sites (RIMS Status Report Number 9)
- ❑ Medical/Health Critical Issues (RIMS Status Report Number 19)
- ❑ Medical mutual aid needs for personnel, supplies and transport (RIMS Status Report Number 10)

Post-Exercise Critiques and Reporting

Exercise debriefings (critiques or "hotwashes") should be conducted by each participating agency and a community-wide debriefing scheduled and conducted by the OA Exercise Contact. To assist the debriefing, there is a "hot wash" (or debriefing points) in this Exercise Contact Toolkit (see page 32) to assist in the evaluation of the exercise. This "hot wash" information will also be needed for the regional and state "hot wash".

Considerations for "hot washes"/debriefings for the Exercise Contact include:

- ❑ Announce the debriefing meeting in advance of the exercise to facilitate participant attendance and preparation for the meeting.
- ❑ Distribute the hotwash/debriefing points in advance of the exercise to allow meeting participants to prepare critiques.
- ❑ Hold debriefing meetings in a convenient location in the community.

- Act as the facilitator and allow the participants from government and private sector organizations to discuss the successes, challenges and needed improvements identified during the exercise.
- Take meeting notes to be provided later to all participants as a feedback mechanism, including those participants who could not attend the critique.
- Develop a list of improvements needed and action items into three categories:
  - –Short Term (less than six weeks to accomplish)
  - –Mid Term (up to three months)
  - –Long Term (greater than three months)
- When possible, organize a work group to follow-up on the action items over the next three months,
- Remind exercise participants to complete the exercise evaluation answer sheets to receive a Certificate of Participation (see below).
- End the meeting on a high note and thank participants for their participation.

Participant Recognition

After the exercise, Certificates of Participation will be issued to all exercise participants upon return of the Exercise Evaluation "Master Answer Sheet" (see the 2004 Statewide Medical and Health Disaster Exercise Guidebook) to:

Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95814
Attn: Disaster Exercise

Additional Information

Should the Exercise Contact wish to have other organizations or people who facilitated the exercise to receive recognition and a certificate of participation or certificate of leadership, please contact Cheryl Starling via email at cheryl.starling@emsa.ca.gov.

End Notes

If you have any questions or inquiries about the 2004 Statewide Medical & Health Disaster Exercise, please contact your Regional Disaster Medical/Health Specialist (RDMHS) or Cheryl Starling, RN at Cheryl.starling@emsa.ca.gov.

EXERCISE OBJECTIVES

Hospital Objectives

Pre-Exercise Event: [Joint Commission on Accreditation of Healthcare Organizations (JCAHO) EC 4.10.2 and EC 4.10.15 and Title 22 70741(b)]
Assess the facility's integration and participation in community-wide emergency management program for preparedness, planning and response. This integration includes area hospitals, public health, public and private emergency medical services (EMS) providers, law enforcement and emergency managers. As a result of this assessment, create collaboration and relationships with important providers to prepare for the exercise and any actual event.

Objective I: [JCAHO EC 4.10.2 and EC 2.9.1]
Implement the facility's emergency preparedness response plan using a recognized incident command system (preferably the Hospital Emergency Incident Command System, or HEICS). Participation in this exercise meets the California Title 22, 70741(d) and JCAHO EC 2.9.1. The Emergency Management Plan must be exercised at least twice per year.

Objective II: [JCAHO EC 4.10.8]
Assess the status of your facility and communicate that status to appropriate governmental agencies within the operational area, utilizing hospital communication systems, if applicable.

Objective III: [JCAHO EC 4.10.10]
Assess the ability to respond to a public health emergency due to a biological terrorism event, including proper infection control procedures, staff and current patient safety, and security of the facility.

Objective IV: [JCAHO LD 4.50, EC 4.10]
Assess the hospital policy, procedure and laboratory staff knowledge of the ability to adjust priorities in response to unusual or urgent events and to collect, package and transport possible bioterrorism specimens to outside labs for analysis, documenting chain of custody.

Objective V: [JCAHO EC 4.10.18]
Implement alternate communication systems to contact public/private medical and health officials, including local government, "sister" and other supportive area facilities or hospitals.

Objective VI: [JCAHO EC 4.10.13]
Assess the response capability of managing an influx of patients and inpatient bed overcrowding and test the plans and procedures to activate alternate care sites.

Objective VII: [JCAHO EC 4.10.10]
Assess the response capability of managing scarce resources (including durable medical equipment, staff).

Objective VIII: [JCAHO EC 4.10.10]
Develop risk communication messages consistent with local authorities in a rapid and timely manner for internal and external dissemination.

EXERCISE OBJECTIVES

Hospital Objectives

Objective IX:
Assess the ability of your facility to communicate the identified threats and appropriate actions to hospital staff, epidemiology investigators and local public health.

Ancillary Healthcare Facility Objectives (Includes skilled nursing, long-term care, psychiatric and clinic facilities)

Objective I:
Implement the facility's emergency preparedness response plan, preferably using a recognized incident command-based system. (See glossary for the Hospital Incident Command System)

Objective II:
Assess the status of your facility and communicate that status to appropriate governmental agencies within the operational area, utilizing appropriate communication systems, if applicable.

Objective III: Assess the ability of your facility to appropriately clear occupied beds and increase bed capacity to accept acute care hospital transfers during this public health crisis.

Ambulance Objectives

Objective I:
Implement the provider's emergency preparedness response plan using a recognized incident command system.

Objective II:
Assess the status of your service and communicate that status to appropriate governmental agencies within the operational area, utilizing appropriate communication systems, if applicable.

Objective III:
Assess the ability to manage transportation of potentially infectious patients due to a biological terrorism event, including infection control measures for EMS personnel and vehicles and the coordination of patient transportation destinations with healthcare facilities and local public health.

Objective IV:
Utilize alternative communication systems to reach appropriate government medical and health contacts, including dispatch and local area hospitals.

EXERCISE OBJECTIVES

Auxiliary Communications Systems (ACS) Objectives

Objective I: (Pre-Exercise)
Coordinate with local auxiliary communications radio operators on frequencies, protocols and forms used during an exercise/actual event.

Objective II:
Test regional/statewide Auxiliary Communication Systems (ACS) and redundant communications in coordination with local amateur radio operators, using established frequencies, protocols and data collection/reporting forms.

Objective III:
Pass two-way communication messages between state, regional and operational area providers.

Operational Area Emergency Operations Center and Exercise Contact

Objective I:
Assess the Operational Area's ability to collect timely, accurate and appropriate data from participants.

Objective II:
Implement Emergency Operations Center's procedures and mechanisms for managing a biological terrorism event, including the procurement, management and allocation of scarce resources within the Operational Area.

Objective III:
Demonstrate the ability to access, enter data into and transmit Response Information Management System (RIMS) data to regional and state medical and health authorities.

Objective IV:
Activate auxiliary communications systems and pass two-way messages to regional and state providers.

Objective V:
Develop risk communication messages consistent with appropriate public health and hospitals in a rapid and timely manner for internal and external dissemination.

EXERCISE OBJECTIVES

Local Public Health Departments

Objective I:
Assess the department's ability to communicate threats and health alerts to healthcare providers, including hospitals, clinics, EMS providers and others.

Objective II:
Demonstrate the ability to act as a conduit for local samples to be analyzed. This includes the ability to communicate with the hospitals and other providers regarding specimen collection, chain of custody for evidence, transport of specimens to the appropriate State facility for analysis, and communication of test results received from the State lab.

Objective III:
Develop risk communication messages consistent with local emergency managers, hospitals and other officials in a rapid and timely manner for internal and external dissemination.

Objective IV:
Assess the local public health surveillance, epidemiology and contact tracing during this biological terrorism event.

Objective V:
Demonstrate the ability to access and transmit information to region and state medical and health authorities through the Response Information Management System (RIMS) and the California Health Alert Network (CAHAN).

State Agencies

Objective I:
Coordinate with the Operational Area and regions for resource requests.

Objective II:
Demonstrate the ability to access and transmit information to region and state medical and health authorities through the Response Information Management System (RIMS) and/or the California Health Alert Network (CAHAN).

Objective III:
Develop risk communication messages consistent with local public health, healthcare agencies and other local/regional officials in a rapid and timely manner for internal and external dissemination.

Objective IV:
Assess the process for and ability to order the Strategic National Stockpile for botulinum antitoxin and durable medical equipment (ventilators).

EXERCISE DAY SCENARIO
8:00 A.M. until 12:00 P.M.

5:00 am Background Scenario

Last night was the Thanksgiving Jubilee, held every year, bringing the community members and large numbers of tourists into town for the celebrations. Hotels, shops and restaurants are usually very busy during the Jubilee and last night was no exception. Everyone was very glad that no incidents or problems occurred during the celebrations, especially law enforcement.

At 5:00 am this morning, Jane, a 47-year-old female, is admitted to the emergency department (ED) complaining of a sudden onset of dizziness, blurred vision, slurred speech, difficulty swallowing, and nausea. She insists that she must be having a stroke, because these are the same symptoms that her father had during his recent stroke. She is very afraid and anxious. During the physical examination, the findings included ptosis, extraocular palsies, facial paralysis and impaired gag reflex. Jane is admitted to the ICU with rule-out CVA.

Over the next hour, the ED received ten more patients with a variety of symptoms from a sore throat to cough and weakness. One child (age 8) requires immediate intubation and mechanical ventilation. The patients presenting with non-acute symptoms are evaluated by the physicians and discharged to home with home care instructions.

Meanwhile in the ICU, Jane develops descending neuroparalysis and is intubated and placed on mechanical ventilation. The critical care and Infectious Disease (ID) physicians suspect a diagnosis of botulism and suspect the transmission as foodborne. Jane's family reported that Jane and her friends attended the Thanksgiving Jubilee last night and ate in the local restaurant. The ID physician happens to call the ED physician to update him on Jane's case, and the ED physician then realizes that many of the patients currently in the ED, and perhaps some that have been discharged, may have ingested botulinum toxin since many of the patients reported having attended the Jubilee. Upon interview of the ED patients, they all report eating out for dinner at restaurants last night, however, they report eating in different venues in the town.

- ☐ **What is your system for identification of trends or clusters of like symptoms?**
- ☐ **What is your hospital procedure for notifying the ED and other pertinent departments of a *probable* diagnosis of botulism?**
- ☐ **What role does your infection control department have in a botulinum event?**
- ☐ **When and how does your hospital send specimens to the Public Health lab, or work with the lab for diagnosis confirmation?**
- ☐ **How would your hospital test and process specimens for a suspected case of botulinum?**

Because of the potential severity of disease and the possibility for exposure of many persons to contaminated products, the physicians know that foodborne botulism, caused by *Clostridium botulinum* (*C. botulinum*), is a potential public health emergency that requires rapid investigation. He contacts the local public health department to report the case and obtain botulism antitoxin for Jane.

- ☐ **What is your hospital policy/procedure for notifying local public health?**

7:30 am

Local public health departments put out an alert over the 24-hour emergency contacting system that an outbreak of botulinum is suspected.

8:00 am The Exercise Begins

The ED has now received a total of 10 patients in the ED with symptoms of foodborne illness, and more patients continue to arrive with similar symptoms. A few have been seen and discharged. Three more patients have developed respiratory depression and descending paralysis and have required mechanical ventilation and ICU admission. The hospital does not have enough ICU beds and has a limited supply of ventilators. You are holding patients waiting to be admitted in the ED and this is severely taxing the ED resources.

- ☐ **When and by whom is the high census plan or procedure activated to free up or add patient beds to accommodate multiple admissions?**
- ☐ **How does the hospital assess, triage, and determine the allocation of scarce resources (ventilators) when confronted by this public health emergency?**
- ☐ **How does the hospital procure additional scarce resources (e.g. ventilators, staffing, inpatient beds, emergency department beds)?**
- ☐ **What are the infection control implications?**

9-1-1 calls begin flooding into dispatch, requesting ambulance transport for multiple family members reporting nausea and weakness. One call reports “person down, not breathing” and EMS is immediately dispatched to that location. The Dispatcher is noticing a definite trend in the calls but does not know what it means.

- ☐ **Should the dispatcher notify anyone of the trend in calls?**
- ☐ **Are there any other procedures that should be activated by EMS/ambulance dispatch?**
- ☐ **What infection control precautions are needed for EMS providers?**

Serum and stool specimens are obtained from the suspect cases and forwarded to the hospital laboratory. The hospital laboratory forwards them to the local public health laboratory for processing through the Laboratory Response Network.

- ☐ **How does local public health notify the community of a public health emergency and communicate the case definition to the healthcare providers?**
- ☐ **What is the procedure for local public health to mobilize teams of epidemiology and contact tracing investigators to determine and isolate the cause of the outbreak?**
- ☐ **What are the infection control implications of this outbreak?**
- ☐ **How and when does local public health inform the State Department of Health Services of the outbreak?**

The California Poison Control Centers are receiving a high volume of calls from adjacent communities. The callers are reporting symptoms including dizziness, nausea, difficulty swallowing and weakness. In taking a short history from the caller, they report having been at the Thanksgiving Jubilee the night before and report eating at the local venues and restaurants. The Poison Control Centers report the trend of callers to local public health.

- ☐ **Does local public health have a mechanism to receive these calls?**
- ☐ **How does the information from the calls into public health get communicated to the local healthcare providers including hospitals, clinics and MD offices?**

A number of patients are presenting to the local community clinics wanting to see the doctor with complaints of dizziness, weakness and facial drooping. There are several patients that require immediate care at the clinic and 9-1-1 is called to transfer them immediately to the ED. Unfortunately, EMS is overtaxed with calls, and cannot get to the clinics immediately.

- ☐ **What communication mechanism does the clinic have with the acute care hospital to alert them of incoming patients?**
- ☐ **What internal procedure(s) or plan(s) should the clinic activate in this situation?**
- ☐ **What other resources does the clinic require for the patient until EMS can arrive to transport the patients to the acute care hospital?**
- ☐ **How does the clinic communicate with local public health to notify them of the patients and to receive assistance?**

9:00 am

The local public health officer declares a local public health emergency based on presenting symptoms and a high index of suspicion of *C. botulinum, and* on the large (and increasing) number of patients, and the early recognition that additional resources will be needed.

The local health dept Department Operations Center (DOC) and County EOC activate.

9:00 am

A local public health epidemiology investigator arrives at the facility to investigate the report of a possible botulism outbreak. The investigator reports that neighboring hospitals are also reporting a high number of patients presenting with similar symptoms of foodborne illness and that physicians are contacting the public health department for notification and to obtain the botulinum antitoxin.

The Mayor's Office receives an anonymous call claiming responsibility for the botulism outbreak. The call is taken seriously because the Mayor's office is aware of the public health emergency, but the information has not yet been released to the public. The caller states that the food supply was deliberately contaminated with *C. botulinum* as an act of terrorism and more contamination could be expected. Local law enforcement is immediately notified and the local FBI contacted. Media has already begun to ask questions and is demanding information at the hospitals.

A decision is made advise the public of the event and to provide public alerts on all media, including television and radio to inform the public. These messages must be well scripted and not evoke public panic.

Considerations and decisions:

- ☐ **What information should be presented to the public?**
- ☐ **What instructions should the public be given?**
- ☐ **Does your agency or hospital have pre-scripted risk communication messages for this public health emergency? If not, what is your process for quickly developing these messages?**
- ☐ **What steps have been taken to ensure a consistent message among the healthcare community and all levels of government agencies/officials?**
- ☐ **What community or governmental agencies should participate in the press conferences? (public health, hospital officials, local government, physicians)**
- ☐ **Who is the most appropriate person(s) to represent the healthcare facility at the press conference(s) and who makes this decision?**
- ☐ **How often should the press conferences be scheduled?**
- ☐ **Where will the press conferences be convened within the community? Who decides the location?**
- ☐ **Who is the "lead" agency for the press conferences?**

Because the event has a terrorism component, local AND national media are intent on "scooping" the story and media are quickly arriving at hospitals, clinics and the local health department to interview staff and victims. In addition, the State Public Health Department is receiving multiple calls and media inquiries.

A press conference is scheduled for 10:00 am with the Mayor, the public health officer, appropriate hospital and clinic representatives and local public safety officials.

9:05 am

The Operational Area (OA) is reporting the following statistics:

(Note: Please customize the OA statistics to simulate mass casualty event and capacity overload. Participants may also simulate the statistics to meet individual needs for exercise play.)

Statistics for the Operational Area (county):

Number of patients admitted with suspected botulism: _____

Number of patients waiting to be seen: _____

Estimated number of persons that may require hospitalization (potential exposures): _____

Number of deceased: _____

10:00 am

The State laboratory confirms *C. botulinum* from the patient samples sent from the local public health department(s). This information is quickly distributed to healthcare providers and the media.

The Press Conference begins. It is announced to the media and the public that there is an outbreak of *C. botulinum* in the community.

The case definition is:

- Systemic flaccid paralysis, starting in and involving the cranial nerves;
- Epidemiological link with the Thanksgiving Jubilee or with other suspect cases in the outbreak, or isolation of toxin in the bloodstream in a patient with the above symptoms.
- Other supporting factors:
    - EMG consistent with botulism and epidemiological link to the outbreak
    - Muscle symptoms consistent with botulism

10:15 am

The Medical and Health Operational Area Coordinator (MHOAC) continues to call hospitals for status reports, bed availability and critical issues.

The intensive care unit(s) within the hospital is at capacity and there are no additional Intensive Care Unit (ICU) beds. The ED is holding _____ numbers (insert appropriate number of ED patients to increase strain on resources) of patients awaiting inpatient beds, including ICU, telemetry and medical-surgical.

Staff in hospitals, clinics and EMS provider agencies are beginning to call in sick for their upcoming shifts. These staff attended the Jubilee, have family members who are ill, or are afraid to come to work. Several on-duty hospital staff have become ill with symptoms of foodborne illness and are reporting to the ED for care.

High census plans are activated and all patients assessed for possible discharge or transfer, all elective surgeries and procedures are cancelled (patients have also been calling the hospitals and outpatient surgery clinics to cancel their surgeries because of fear of coming to the hospital).

To respond to the surge of patients, plans to augment staff and maximize current staffing resources are activated, including:

- ✓ Activation of call-back of staff
- ✓ Alteration of shift times, including implementation of 12-16-hour shifts
- ✓ Pre-scheduling staff to alternate shifts (a.m., p.m., noc) to maximize allocation of current resources and ensure 24-hour-a-day staffing

The influx of patients presenting to the ED continues in a steady stream, overwhelming resources, including staff (all levels of healthcare providers), lack of ED space, patient care equipment (gurneys, oximeters, ventilators, oxygen sources) and supplies (medications, patient care supplies).

- ☐ **What procedures or plans does the hospital have to expand treatment area space?**
- ☐ **If you received a Casualty Management Shelter from the HRSA funds, set the tent up and utilize it in the exercise.**
- ☐ **What is the procedure for exempting the facility from DHS licensing and certification for the nurse staffing ratios during this emergency?**
- ☐ **What additional areas within or outside of your facility can be used to provide patient care?**
- ☐ **What is your procedure for notifying DHS Licensing and Certification about plans to utilize alternate care sites?**

Local public health has mobilized teams of epidemiology investigators to determine the mechanism of the outbreak and they are arriving at the hospitals. They ask to interview patients and families immediately.

- ☐ **What identification and information will you need from the public health investigators on arrival to the hospital?**
- ☐ **What access will the investigators have to hospital records?**

_____ number (*Insert number to stress the facility and coroner system*) of patients have died and are awaiting coroner to investigate and remove the bodies. The hospital must identify a secure area to hold the bodies until they arrive. Law enforcement and FBI are at the hospital demanding to interview victims, families and review medical records.

- ☐ **What is your hospital policy on interacting with law enforcement, evidence collection, and protecting patient privacy?**

- ☐ **Where will you stage law enforcement officials within your facility to allow for interviews but not congest patient care areas?**

- ☐ **What is the back up plan to store bodies when the morgue is not adequate size or capacity?**
- ☐ **Are the bodies considered "contaminated", and if so, what special precautions should be taken for disposition of remains?**

EMS continues to report an increased volume of 911 calls requiring transport to the hospital. The hospitals have been on and off diversion for the last few hours. Now, all diversion has been suspended by the local EMS Agency (LEMSA) due to the public health emergency, and all hospitals are taking ambulance traffic. With the volume of 911 calls requiring ambulance transport and high ED and inpatient censuses, EMS providers are greatly delayed in delivering the patient and transferring the care of the patient to the hospital staff upon arrival, resulting in decreased availability of EMS responders to 911 calls.

Since the press briefing and media alerts, the public that attended the Thanksgiving Jubilee are flocking to clinics and MD offices, demanding to be treated even if they have no symptoms. They are demanding to be seen "just in case". Security of the clinic has become a critical issue that must be addressed immediately.

- ☐ **What internal policies and procedures does the clinic have for security and containing the influx of patients into the facility?**
- ☐ **What agencies can be contacted to provide additional security for critical clinic facilities?**
- ☐ **What community resources can be utilized to assist in patient management, including mental health issues?**

10:30 am

A supply of botulinum antitoxin arrives at the local public health department for distribution to the hospitals. The county has only received _____ doses of antitoxin. Local public health must determine what patients will receive the antitoxin and distribute the medication to the facilities.

- ☐ **How will hospitals communicate their need for antitoxin to the local health department? Which patients will receive the antitoxin?**
- ☐ **How will the local public health department communicate the decisions on antitoxin to the hospitals and to the public?**
- ☐ **How is your organization dealing with the mental health concerns of the staff and the public?**

Botulism does not spread from person to person, but patients will need weeks to months of supportive care before recovery, most requiring respiratory support. Scarce resources and patient management will be long-term issues for the facility and the community.

- **What are the long term implications of this outbreak for your organization and your community?**
- **What recovery and mitigation efforts can you take now to reduce the impact of this event?**
- **As an acute care facility, have you integrated ancillary care facilities into your plans to accommodate a surge of patients?**
- **As an ancillary care facility (e.g. skilled nursing facility), does your emergency management plan integrate and coordinate with acute care facilities to accommodate a surge of long-term care patients in the community?**

Hospitals, clinics, EMS and local public health construct contingency plans to address the upcoming critical shortages. Vendors are contacted to provide the additional supplies and equipment.

Considerations and possible actions:

- **Activate current processes and procedures to procure essential resources needed currently and within 12 hours.**
- **Is there a plan to ration resources?**
- **What resources and mechanisms are available to procure the needed supplies and equipment and who or what agency is contacted to provide those resources?**
  - **Intra-hospital resources**
  - **Inter-hospital resources**
  - **Community resources, including city and county**
  - **County resources, including the MHOAC in the EOC**
  - **Others**
- **What are the proper channels of communication and who or what agency is contacted to obtain those resources?**
- **What non-medical resources may be needed in the event? (i.e. security, law enforcement, sanitation, water, transportation)**

11:00 am

The press conference has spurred an overwhelming number of phone calls, both landline and cellular coming into and going out of the community. Local phone lines and cell sites are unable to accommodate the surge of calls and the phone systems go down. The loss of phone lines also interrupts communications with the California Health Alert Network (CAHAN). The hospitals, clinics, EMS providers and public health and county EOC are unable to place or receive calls.

Auxiliary Communication Systems (ACS) plans are activated. Local ACS members respond to provide critical communications as per current plans and procedures. (Note: the ACS Exercise Guidebook can be downloaded from the website at www.emsa.ca.gov.) This ACS Exercise Guidebook provides two-way messages from the region to the state. The focus of the two-way messages is to encourage traffic between the Operational Areas to the Region and Region to

State. However, local ACS provider may utilize the messages to stimulate traffic among healthcare providers (hospitals, EMS, clinics, etc.) and the OA EOC or other appropriate agencies.

- ☐ **What other redundant communication systems exist at the facility, agency and local level to continue communications during the declared public health emergency?**

11:15 am

Local public health officials announce that the cause of the outbreak of *C. botulinum* is from salad bars in restaurants and open venues at the Jubilee. It is determined that this was terrorism related and the public is warned to take all precautions for food safety.

11:30 am

Phone service has been reestablished in the area. However, the phone company has stated that service may be intermittent due to volume.

- ☐ **What decisions should be made about maintaining the ACS communication functions?**

.

All facilities, agencies and providers report status to the OA. The OA and EOC compile the reports, enter information into RIMS and place mission requests as appropriate.

The Regional Emergency Operations Center (REOC) begins to receive reports from the OA and relays the information and resource requests to the Joint Emergency Operations Center (JEOC) and the State Operations Center.

12:00 pm **THE EXERCISE ENDS**

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

OPERATIONAL AREA INTENT TO PARTICIPATE

The Medical/Health Exercise Contact will complete this form and fax to your Regional Disaster Medical/Health Specialist (listed on page 23)
by FRIDAY, September 10, 2004.

Operational Area (County): _____

Operational Area Medical/Health
Exercise Contact Name: _____

Address: _____

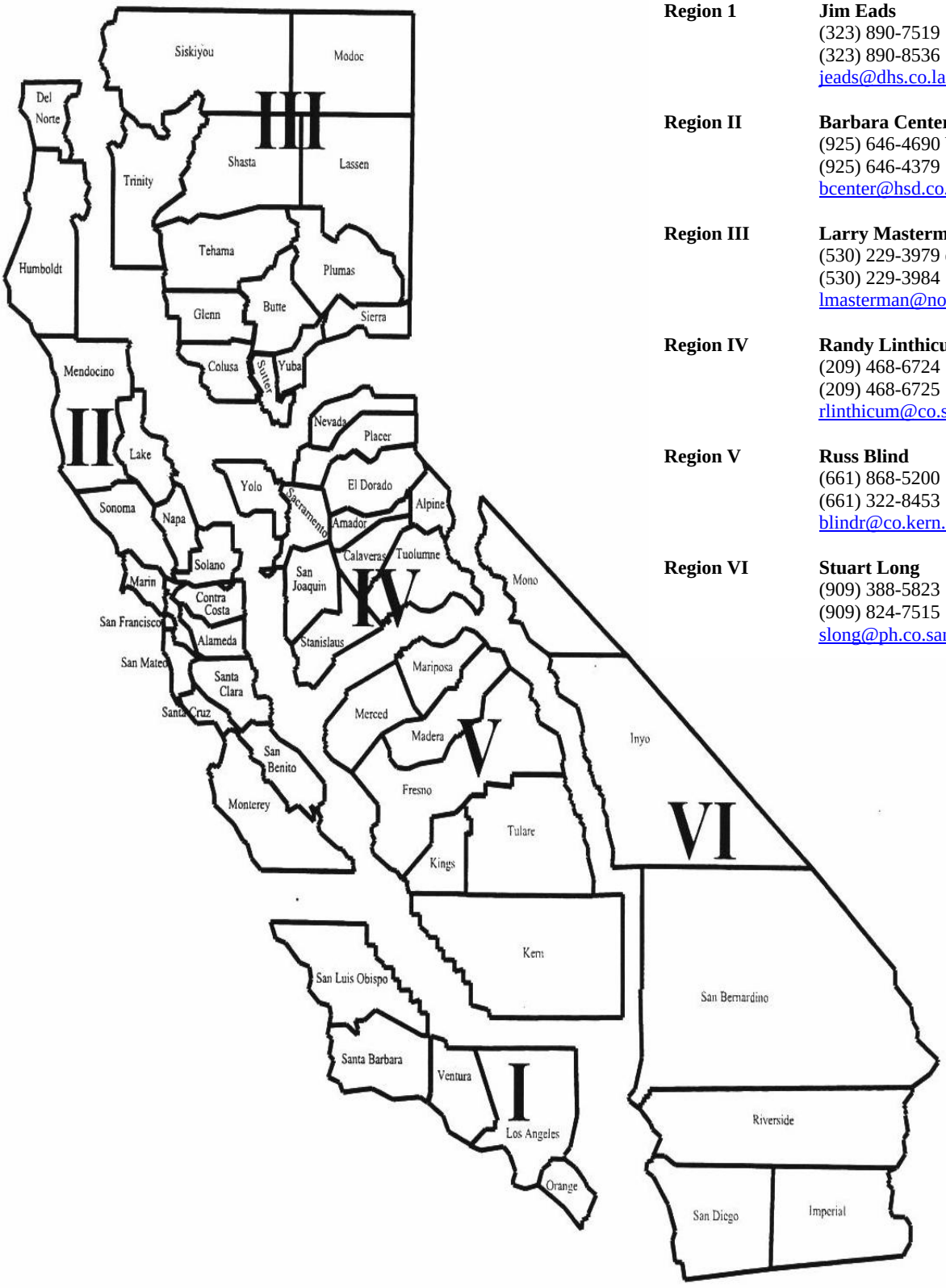
City: _____ Zip: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Operational Area Agencies	**Intent to Participate in the Operational Area Exercise (Check One Column)**		
	Yes, Will Participate		**No, Will Not Participate**
Local Emergency Medical Services Agency			
Local Health Officer/Public Health			
Operational Area Disaster Medical/Health Coordinator			
Local Office of Emergency Services			
Auxiliary Communications Systems			
Other- Specify:			
Operational Area Participants	**Total number in County**	**Yes, will Participate (Enter Number Participating)**	**No, Will Not Participate**
Hospitals: Acute Care			
Other Healthcare facilities (SNF)			
Psychiatric Hospitals, facilities			
Clinics			
Other (specify):			
Ambulance Providers and Agencies:			
ALS			
BLS			
Other- Specify:			
Other- Specify:			
Other- Specify:			
Other- Specify:			

Mutual Aid Regions and RDMHS Staff



Region 1 — **Jim Eads**
(323) 890-7519 Voice
(323) 890-8536 Fax
jeads@dhs.co.la.ca.us

Region II — **Barbara Center**
(925) 646-4690 Voice
(925) 646-4379 Fax
bcenter@hsd.co.contra-costa.ca.us

Region III — **Larry Masterman**
(530) 229-3979 ext. 206 Voice
(530) 229-3984 Fax
lmasterman@norcalems.org

Region IV — **Randy Linthicum**
(209) 468-6724 Voice
(209) 468-6725 Fax
rlinthicum@co.san-joaquin.ca.us

Region V — **Russ Blind**
(661) 868-5200 Voice
(661) 322-8453 Fax
blindr@co.kern.ca.us

Region VI — **Stuart Long**
(909) 388-5823 Voice
(909) 824-7515 Fax
slong@ph.co.san-bernardino.ca.us

"Hotwash"

After-Action Debriefing

This is a suggested list of questions recommended for incorporation into the debriefing or "hotwash" for the exercise participants. Please elicit as much detail as possible and compile the information.

It is recommended to appoint one person to conduct the debriefing and to moderate as required. A scribe can be directed to track and document comments and recommendations made by the participants during the hotwash. The Operational Area (County) Disaster Medical/Health Exercise Contact, or designee, should compile and submit the hotwash information to the Regional Disaster Medical/Health Specialist (RDMHS) during a regional hotwash to be announced at a later date.

It is suggested to schedule the operational area debriefing no later than December 10, 2004 or as soon as possible after the exercise.

Debriefing Questions

1. Was the information contained in the Disaster Exercise Guidebook clear and concise? What changes/additions would you suggest?
2. Was the "Intent to Participate" form user friendly? Would you suggest any additions or deletions?
3. Were the "Exercise Objectives" clear and applicable to a potential real life situation?
4. Was the "Exercise Scenario" realistic, useful and clear?
5. Did you change or expand the exercise scenario to meet the needs of your facility? If so, how?
6. What items/sections of the Disaster Exercise Guidebook were not helpful?
7. Any suggestions for improvement in any of the items or sections of the Disaster Exercise Guidebook?
8. Were the pre-exercise time frames/expectations reasonable? What would you do differently?
9. Did you utilize the "Sample PIO Media Advisory? Was it worthwhile having as a reference in the Exercise Guidebook?

10. Did you test communication systems?
    a. Did you use an alternative communication system during the exercise (i.e. ACS)?
       If yes:
       i. Describe the benefits and/or problems with data transmission via ACS radio.
       ii. Were two-way messages sent and received?
       iii. Was the specific information requested from hospitals, ambulance providers and others useful?
       iv. What would you add/delete?
       v. How would you resolve any problems or issues in the future?
    b. Did you use other communication technologies during the exercise (i.e. fax, email, internet, etc.)?
       If yes: What were the benefits and what worked well?
       What did not work well, what problems or issues did you have?
       How would you resolve any problems or issues in the future?

11. Describe the use of the Response Information Management System (RIMS) in your county.

    a. Where and by whom was the information entered into RIMS?
    b. Was the information requested from the hospitals pertinent to the situation and helpful to you?
    c. Will the overall medical/health information requested on the RIMS forms be pertinent in a real life situation?
    d. What suggestions would you offer for revisions to the medical/health RIMS data?
    e. What training, administrative or logistical issues need to be addressed?

    f. If the Operational Area's Emergency Operations Center was activated:

    g. Was the interaction with disaster management officials at the operational area's EOC useful and provide you with direction, information and assistance?
    h. Describe your interaction with the EOC in your operational area.
       i. What worked well?
       ii. What could be improved?

    i. What training issues or points did you identify during the exercise that needs to be addressed before the next exercise/actual event?

    j. Was the Exercise Contact Toolkit helpful?

    k. Did you utilize the Toolkit in preparing for the Exercise?
    l. How could the Toolkit be improved next year?

    m. Any other issues or items for the debriefing?

Glossary of Terms

Auxiliary Communications Services (ACS)	The Auxiliary Communications Service (ACS) is an emergency communications unit that provides State and local government with a variety of professional unpaid [volunteer] skills, including administrative, technical and operational for emergency tactical, administrative and logistical communications. ACS works with agencies and cities within the Operational Area, neighboring governments and the State OES Region. Its basic mission is the emergency support of civil defense, disaster response and recovery with telecommunications resources and personnel. **CARES: California Amateur Radio Emergency Services** CARES is specifically tasked to provide amateur radio communications support for the medical and health disaster response to state government. **RACES: Radio Amateur Civilian Emergency Services** RACES is a local or state government program established by a civil defense official. It becomes operational by: 1) appointing a radio officer; 2) preparing a RACES plan; and 3) training and utilizing FCC licensed amateur radio operators. RACES, whether part of an ACS or as a stand alone unit, is usually attached to a state or local government's emergency preparedness office or to a department designated by that office, such as the sheriff's or communications department.
Bioterrorism	The intentional or threatened use of viruses, bacteria, fungi or toxins from living organisms to produce death or disease in humans, animals or plants.
Botulism	Botulism is a muscle-paralyzing disease caused by a toxin made by a bacterium called *Clostridium botulinum*. **There are three main kinds of botulism:** • Foodborne botulism occurs when a person ingests pre-formed toxin that leads to illness within a few hours to days. Foodborne botulism is a public health emergency because the contaminated food may still be available to other persons besides the patient. • Infant botulism occurs in a small number of susceptible infants each year who harbor *C. botulinum* in their intestinal tract. • Wound botulism occurs when wounds are infected with *C. botulinum* that secretes the toxin.
Disease Surveillance	In epidemiology and public health, the identification of index patients and their contacts; the detection of outbreaks and epidemics; the determination of the incidence and demographics of an illness; and the policy-making that may prevent further spreading of disease.

Glossary of Terms

Emergency	A condition of disaster or of extreme peril to the safety of persons and property caused by such conditions as air pollution, fire, flood, hazardous material incident, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestations or disease, an earthquake or volcanic eruption.
Emergency Management	The organized analysis, planning, decision making, assignment and coordination of available resources to the mitigation of, preparedness for, response to or recovery from emergencies of any kind, whether from man-made attack or natural sources.
Emergency Operations Center	A centralized location from which emergency operations can be directed and coordinated.
Epidemic	An infectious disease or condition that attacks many people at the same time in the same geographical area.
Epidemiology	The study of the distribution and determinants of health-related states and events in populations, and the application of this study to the control of health problems. Epidemiology is concerned with the traditional study of epidemic diseases caused by infectious agents, and with health-related phenomena.
Exercise	**Functional:** The functional exercise is an activity designed to test or evaluate the capabilities of the disaster response system. It can take place in the location where the activity might normally take place, such as the command center or incident command post. It can involve deploying equipment in a limited, function-specific capacity. This exercise is fully simulated with written or verbal messages. **Full Scale:** This type of exercise is intended to evaluate the operational capability of emergency responders in an interactive manner over a substantial period of time. It involves the testing of a major portion of the basic elements existing in the emergency operations plans and organizations in a stress environment. Personnel and resources are mobilized. **Tabletop:** An exercise that takes place in a classroom or meeting room setting. Situations and problems presented in the form of written or verbal questions generate discussions of actions to be taken based upon the emergency plan and standard emergency operating procedures. The purpose is to have participants practice problem solving and resolve questions of coordination and assignment in a non-threatening format, under minimal stress. **Communications:** The communications exercise is designed to test and evaluate communication systems, including lines and methods of communicating during a disaster. Alternative communication systems can also be tested, including amateur radio, cell and satellite systems, among others.

Glossary of Terms

Hospital Emergency Incident Command System (HEICS)	HEICS is an emergency management system that employs a logical, unified management (command) structure, defined responsibilities, clear reporting channels and a common nomenclature to help unify hospitals with other emergency responders. Information on HEICS can be obtained through the California EMSA website at www.emsa.ca.gov.
Incident Command System (ICS)	The nationally used standardized on-scene emergency management concept is specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demand of single or multiple incidents without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, with the responsibility of managing resources to effectively accomplish stated objectives pertinent to an incident.
Incubation Period	The interval between exposure to infection and the appearance of the first symptom.
Index Patient	An instance of a disease or a genetically determined condition that is discovered first and leads to the discovery of others in a family or population.
Isolation	The physical separation of infected or contaminated organisms from others to prevent or limit the transmission of disease. In contrast, quarantine applies to restriction on healthy contacts of an infectious agent.
Joint Emergency Operations Center (JEOC)	A unified operations center established by the State Emergency Medical Services Authority and Department of Health Services to manage the State-level medical and health response to disasters, including the use of state resources.
Long-Term Care Facilities	A collective term for healthcare facilities designated for the care and treatment of patients or residents requiring rehabilitation or extended care for chronic conditions. The Department of Health Services, Licensing and Certification Division licenses these facilities.
Mass Prophylaxis	The provision of medications and/or vaccines to large numbers of the public to prevent or treat an infectious disease.
Medical and Health Operational Area Coordinator (MHOAC)	The OAC is responsible for coordinating mutual aid resource requests, facilitating the development of local medical/health response plans and implementing the medical/health plans during a disaster response. During a disaster, the OAC directs the medical/health branch of the Operational Area EOC and establishes priorities for medical/health response and requests. This coordinator was formerly known as the Operational Area Disaster Medical/Health Coordinator.
NIMS	The National Incident Management System, developed under Homeland Security Presidential Directive 5, provides a consistent nationwide approach for federal, state, local and tribal governments to work effectively to prepare for, respond to and recover form domestic incidents.

Glossary of Terms

Operational Area	An intermediate level of the State emergency services organization, consisting of a county and all political subdivisions within the county.
Pandemic	A disease affecting the majority of the population of a large region or one that is epidemic at the same time in many different parts of the world.
Regional Emergency Operations Center (REOC)	The Regional Emergency Operations Center (REOC) is the first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the operational areas and coordinates with the State Operations Center.
Regional Disaster Medical and Health Coordinators (RDMHC)	At the regional level, EMSA and DHS jointly appoint Regional Disaster Medical and Health Coordinator (RDMHC) whose responsibilities include supporting the mutual aid requests of the MHOAC for disaster response within the region and providing mutual aid support to other areas of the state in support of the state medical response system. The RDMHC also serves as an information source to the state medical and health response system.
Standardized Emergency Management System (SEMS)	SEMS is the emergency management system identified by Government code 8607 for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the Incident Command System and is intended to standardize response to emergencies in California.
State Operations Center (SOC)	The SOC is established by OES to oversee, as necessary, the REOC, and is activated when more than one REOC is opened. The SOC establishes overall response priorities and coordinates with federal responders.

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT INFORMATION
Alameda	Jim Morrissey Alameda EMS 1000 San Leandro Blvd. Ste 100 San Leandro, CA 94577	Phone: 510-618-2036 Fax: 510-618-2099 Pager: 415-208-0936 Email: jim.morrissey@acgov.org
Alpine Amador Calaveras Stanislaus	Doug Buchanan Deputy Director Mountain Valley EMS 1101 Standiford Avenue Modesto, CA 95350	Phone: 209-529-5085 Fax: 209-529-1496 Email: dbuchanan@mvemsa.com
Butte	Dr. Mark Lundberg Health Officer 202 Mira Loma Oroville, CA 95965	Phone: 530-538-7581 Fax: 530-538-2165 Email: mlundberg@buttecounty.net
Colusa	Georgeanne Hulbert 251 E. Webster Street Colusa, CA 95932	Phone: 530-458-0380 Fax: 530-458-4136 Email: ghulbert@colusadhhs.org
Contra Costa	Dan Guerra Contra Costa EMS 1340 Arnold Drive, Ste. 126 Martinez, CA 94590	Phone: 925-646-4690 Fax: 925-646-4379 Email: DGuerra@hsd.co.contra-costa.ca.us
Del Norte	Kathy Stephens Del Norte County Health Dept. 880 Northcrest Drive Crescent City, CA 95531	Phone: 707-464-7227 (3191) x308 Fax: 707-465-6701 Email: kstephens@co.del-norte.ca.us
El Dorado	Merry Holliday-Hanson Public Health Dept. 415 Placerville Drive, Suite R Placerville, CA 95667	Phone: 530-621-7628 Fax: 530-621-4781 Email: mhollida@co.el-dorado.ca.us
Central California EMS Agency (Fresno, Kings, Madera, Tulare)	Lee Adley PO Box 11867 Fresno, CA 93775	Phone: 559-445-3387 Fax: 559-445-3205 Email: Ladley@fresno.ca.gov
Glenn	Grinnell Norton Public Health 240 N. Villa Avenue Willows, CA 95988	Phone: 530-934-6588 Fax: 530-934-6463 Email: gnorton@glenncountyhealth.net

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT NUMBERS
Humboldt	Clarke Guzzi Humboldt Public Health 529 "I" St. Eureka, CA 95510	Phone: 707-268-2187 Fax: 707-445-6097 Email: cguzzi@co.humboldt.ca.us
Imperial	John Pritting 935 Broadway El Centro, CA 92243	Phone: 760-482-4468 Fax: 760-482-4519 Email: johnpritting@imperialcounty.net
Inyo	Tamara Pound PO Box Drawer H Independence, CA 93526	Phone: 760-878-0232 Fax: 760-878-0266 Email: inyohhs@qnet.com
Kern	Russ Blind Senior Coordinator 1400 H Street Bakersfield, CA 93301	Phone: 661-868-5201 Fax: 661-322-8453 Email: blindr@co.kern.ca.us
Lake	Craig McMillan Lake Co. Dept. of Health 922 Bevins Court Lakeport, CA 95453	Phone: 707-263-1090 Fax: 707-262-4280 Email: craigm@co.lake.ca.us
Lassen	Chip Jackson OES 220 S. Lassen, Suite 1 Susanville, CA 96130	Phone: 530-251-8222 Fax: 530-257-9363 Email: sheriff@co.lassen.ca.us
Los Angeles	Larry Smith Disaster Coordinator 5555 Ferguson Drive, Suite 220 Commerce, CA 90022	Phone: (323) 890-7559 Fax: (323) 890-8536 Email: lasmith@dhs.co.la.ca.us
Marin	Troy Peterson, MHOAC Division of Public Health 20 North San Pedro # 2004 San Rafael, CA 94903	Phone: 415-499-3287 Fax: 415-473-2326 Email: tpeterson@co.marin.ca.us
Mariposa	Dana Tafoya Mountain Valley EMS 1101 Standiford Ave Modesto, CA 95350	Phone: 209-966-3689 Fax: 209-966-4929 Email: dtafoya@mvemsa.com
Mendocino	Steve Francis Coastal Valley EMS Mendocino 1120 South Dora Street Ukiah, CA 95482	Phone: 707-472-2785 Fax: 707-472-2788 Email: franciss@co.mendocino.ca.us
Merced	Ron Duran EMS Specialist 260 E. 15th Street Merced, CA 95340	Phone: 209-381-1260 Fax: 209-381-1259 Email: rduran@co.merced.ca.us

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT NUMBERS
Modoc	Linda Doyle, RN CIC Modoc Co. Health Dept. 441 N. Main Street Alturas, CA 96101	Phone (530) 233.6343 Fax: (530) 233.6332 E-mail: ldoyle@hdo.net
Mono	Richard O. Johnson M.D. Mono County Public Health Officer POB 3329 437 Old Mammoth Rd., #Q Mammoth Lakes, CA 93546	Phone: (760) 924-1828 Fax: (760) 924-1831 E-mail: rjohnson@mono.ca.gov
Monterey	John Sherwin Monterey EMS 19065 Portola Dr. Ste I Salinas, CA 93908	Phone: 831-755-5013 Fax: 831-455-0680 Email: sherwinJ@co.monterey.ca.us
Napa	Bonny Martignoni Coastal Valley EMS/Napa 1721 First St. Napa, CA 94559	: 707-253-4345 Fax: Fax: (707) 259-8112 Email: bmartign@co.napa.ca.us
Nevada	Henry Foley Community Health 10433 Willow Valley Road Nevada City, CA 95959	Phone: 530-265-1459 Fax: 530-265-1426 Email: henry.foley@co.nevada.ca.us
Orange	Bryan Hanley Disaster Coordinator 405 West Fifth Street, Suite 301A Santa Ana, CA 92701	Phone: 714-834-3124 Fax: 714-834-3125 Email: bhanley@hca.co.orange.ca.us
Placer	Rui Cunha Placer County OES 2968 Richardson Street Auburn, CA 95603	Phone: 530-886-5300 Fax: 530-886-5343 Email: rcunha@placer.ca.gov
Plumas	Tina Venable Health Dept. PO Box 3140 Quincy, CA 95971	Phone: 530-283-6346 Fax: 530-283-6110 Email: tinavenable@countyofplumas.com
Riverside	Britta Myrin 4065 County Circle Drive Post Office Box 7600 Riverside, CA 92513	Phone: 909-358-7100 Fax: 909-358-7105 Email: bmyrin@co.riverside.ca.us
Sacramento	Bruce Wagner Sacramento Co. EMS 9616 Micron Avenue, Suite 635 Sacramento, CA 95827	Phone: 916-875-9753 Fax: 916-875-9711 Email: wagnerems@msn.com

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT NUMBERS
San Benito	Margie M. Riopel San Benito County, EMS 471 Fourth St. Holllister, CA 95023	Phone: 831-636-4168 Fax: 831-636-4104 Email: mriopel@oes.co.san-benito.ca.us
San Bernardino	Marlene Goodell Medical/Health Disaster Coordinator 351 N Mountain View San Bernardino, CA 92415-0010	Phone: 909-387-6835 Fax: 909-387-0126 Email: mgoodell@ph.co.san-bernardino.ca.us
San Diego	Jeri Bonesteele 6255 Mission Gorge Road San Diego, CA 92120	Phone: 619-285-6505 Fax: 619-285-6531 Email: jboneshe@co.san-diego.ca.us
San Francisco	Steve LaPlante San Francisco EMS 68-12th Street, Suite 220 San Francisco, CA 94103	Phone: 415-355-2606 Fax: 415-552-0194 Email: steve.laplante@sfdph.org
San Joaquin	Darrell Cramphorn San Joaquin EMS PO Box 1020 Stockton, CA 95201	Phone: 209-468-6818 Fax: 209-468-6725 Email: dcramphorn@co.san-joaquin.ca.us
San Luis Obispo	Tom Lynch, MHOAC 712 Fiero Lane, #29 San Luis Obispo, CA 93401	Phone: (805) 546-8728 Fax: (805) 546-8736 Email: sloemsa@fix.net
San Mateo	Matt Lucett San Mateo EMS 225 37th Avenue San Mateo, CA 94403	Phone: 650-573-2737 Fax: 650-573-2029 Email: mlucett@co.sanmateo.ca.us
Santa Barbara	Nancy LaPolla MHOAC/EMS Administrator 300 North San Antonio Road Santa Barbara, CA 93110-1316	Phone: 805-681-5274 Fax: 805-681-5142 Email: nlapoll@co.santa-barbara.ca.us
Santa Clara	Bruce H. Lee EMS Administrator 645 South Bascom Avenue San Jose, CA 95128	Phone: 408-885-4250 Fax: 408-885-3538 Email: bruceh.lee@hhs.co.scl.ca.us

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT NUMBERS
Santa Cruz	Celia Barry Santa Cruz EMS 1080 Emeline Avenue Santa Cruz, CA 95060	Phone: (831) 454-4751 Fax: (831) 454-4272 Email: Celia.Barry@health.co.santa-cruz.ca.us
Shasta	John Duffy Dept. of Public Health 2650 Breslauer Way Redding, CA 96001	Phone: 530-229-8498 Fax: 530-225-5344 Email: jduffy@co.shasta.ca.us
Sierra	Liz Fisher OES PO Box 513 Downieville, CA 95936	Phone: 530-289-2850 Fax: 530-289-2849 Email: lfisher@sierracounty.ws
Sutter	John DeBeaux Emergency Services Division 1130 Civic Center Blvd. Yuba City, CA 95993	Phone: 530-822-7400 Fax: 530-822-7109 Email: jdebeaux@co.sutter.ca.us
Solano	Michael Modrich Solano EMS 275 Beck Ave. MS 5 - 240 Fairfield, CA 94533	Phone: 707-784-8155 Fax: 707-421-6682 Email: mmodrich@solanocounty.com
Sonoma	Mike DuVall Coastal Valley EMS 3273 Airway Dr. Ste E Santa Rosa, CA 95403-2097	Phone: 707-565-6501/6506 Fax: 707-565-6510 Email: mduvall@sonoma-county.org
Sutter	John DeBeaux Emergency Services Division 1130 Civic Center Blvd. Yuba City, CA 95993	Phone: 530-822-7400 Fax: 530-822-7109 Email: jdebeaux@co.sutter.ca.us
Tehama	Donna S. Wenz, RN TCHSA-PHD PO Box 400 Red Bluff, CA 96080	Phone: 530-527-6824 Fax: 530-527-0362 Email: wenzd@tcha.net
Trinity	Elise Osvold-Doppelhaur, PHN Health Dept. PO Box 1470 Weaverville, CA 96093	Phone: 530-623-8215 Fax: 530-623-1297 Email: eosvolddoppelhauer@trinitycounty.org

2004 Statewide Medical and Health Disaster Exercise
Emergency Medical Services Authority
November 18, 2004
Exercise Contact Toolkit

Operational Area (County) Medical/Health Exercise Contacts

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT NUMBERS
Tuolumne	Dan Burch Tuolumne EMS 20111 Cedar Road North Sonora, CA 95370	Phone: (209) 533-7460 Fax: 209-533-4761 Email: dburch@co.tuolumne.ca.us
Ventura	Steve Carroll, Disaster Coordinator 2220 East Gonzales Road, Suite 130 Oxnard, CA 93036	Phone: 805-981-5305 Fax- 805-981-5300 Email: steve.carroll@mail.co.ventura.ca.us
Yolo	Dan McCanta Yolo OES 35 North Cottonwood Street Woodland, CA 95698	Phone: 530-666-8930 Fax: 530-666-8909 Email: dan.mccanta@yolocounty.org
Yuba	Kent McClain County Administrative Officer 215 5th St. Marysville, CA 95901	Phone: 530-749-7575 Fax: 530-741-6549 Email: kmcclain@co.yuba.ca.us

The Emergency Medical Services Authority would like to thank the Disaster Exercise Planning Group members for their contribution to the 2004 Statewide Medical and Health Disaster Exercise Guidebook and planning process.

Disaster Exercise Planning Group Members include:

Cheryl Starling, RN, Exercise Chair, Emergency Medical Services Authority
Jean Bennett, Area Emergency Manager, Veteran's Administration
Barbara Center, RDMHS, Region II
Dr. Don Cheu, San Mateo County
Jim Eads, RDMHS, Region I
Jocelyn Montgomery, Department of Health Services, Licensing and Certification
Yvonne Morales, Hospital Bioterrorism Preparedness Program
Carolyn Moussa, Governor's Office of Emergency Services
David Otey, Kaiser Permanente
Dr. Christian Sandrock, UC Davis Medical Center, HBPP Medical Director
Steve Sasson, California Department of Health Services
Dr. Arnie Spanjers, Kaiser Permanente
Ann Stangby, RN, San Francisco Public Health Department